OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES

GENERAL HEALTH CHECKLIST

Full Name _____ Social Security Number _____

Date of Birth _____ Height _____ Weight _____

Please answer "Yes" or "No" to all items.

Do you have. . . .		**YES**	**NO**	**IF YES, HAS IT KEPT YOU FROM WORKING? YES**	**NO**
1.	A disorder of eyes, ears, nose or throat?	☐	☐	☐	☐
2.	Frequent dizziness, fainting, or headache; seizures, convulsions, paralysis, or stroke?	☐	☐	☐	☐
3.	A mental or nervous disorder?	☐	☐	☐	☐
4.	Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs?	☐	☐	☐	☐
5.	Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorder of the heart or blood vessels?	☐	☐	☐	☐
6.	Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gallbladder?	☐	☐	☐	☐
7.	Disorder of kidney, bladder, prostate or reproductive system?	☐	☐	☐	☐
8.	Diabetes, thyroid, or other endocrine disorders?	☐	☐	☐	☐
9.	Arthritis or other disorder of the muscles or bones, including the spine, back or joints?	☐	☐	☐	☐
10.	Absence or amputation of any body part?	☐	☐	☐	☐
11.	Loss of use of arms and legs or other body part?	☐	☐	☐	☐
12.	A tumor, cancer, or disorder of skin or lymph glands?	☐	☐	☐	☐
13.	Allergies?	☐	☐	☐	☐
14.	Anemia or other disorder of the blood?	☐	☐	☐	☐
15.	Excessive use of alcohol or any habit-forming drugs?	☐	☐	☐	☐
16.	Any other physical or mental condition?	☐	☐	☐	☐

If yes, specify: _____

17. Name and address of your personal physician/clinic: (if none, so state)

_____

PLEASE ANSWER THESE QUESTIONS FOR ANY CONDITION MARKED "YES" ON THE FIRST PAGE:

18. Have you been or are you being treated for any of these conditions? ☐ YES ☐ NO

If **No**, why not? _____

If **YES**, Condition | Dr. Name & Address | Phone Number | Dates Seen

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

19. Have you been hospitalized for any of these conditions? ☐ YES ☐ NO

If **YES**, Condition | Hospital | When?

_____ _____ _____

_____ _____ _____

_____ _____ _____

20. Are you taking any medicines? ☐ YES ☐ NO

If YES, Condition | Medicine | Condition | Medicine

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

21. Do you have any restrictions from these conditions? ☐ YES ☐ NO

If YES, Condition | What restrictions?

_____ _____

_____ _____

_____ _____

To the best of my knowledge, what I have said is true and I have not withheld any information.

_____ _____

(Date) (Signature of applicant)

Person who provided information, if not applicant: _____

Comments:

Once you complete the application, please print it out. Check to see that all three (3) pages printed.

Call for an appointment and bring the application with you, along with any pertinent medical records.

To find the nearest office, call 1-800-487-4042.